STATE OF CALIFORNIA

DUPLICATE WAGE AND TAX STATEMENT REQUEST

STD. 436 (REV. 1-97)

FOR SCO USE ONLY
DATE
CHECK NUMBER
CHECK AMOUNT
INITIALS

TO: **STATE CONTROLLER'S OFFICE**
PERSONNEL/PAYROLL SERVICES DIVISION
ATTN: ADMINISTRATIVE SUPPORT UNIT
P. O. BOX 942850
SACRAMENTO, CA 94250-5878

NOTE: *This form must be filled out in its entirety. Include a processing fee for **EACH TAX YEAR** requested.*

SOCIAL SECURITY NUMBER	NAME

TAX YEAR(S) REQUESTED *(Available only for 4 prior tax years)*

YEAR(S)				

DUPLICATE WAGE AND TAX STATEMENT SHOULD BE MAILED TO *(Check one)*

☐ EMPLOYEE ADDRESS ☐ DEPARTMENT ADDRESS

MAILING ADDRESS *(Please print)*

EMPLOYEE / DEPARTMENT NAME	DAYTIME TELEPHONE NUMBER *(Include Area Code)*

NUMBER AND STREET

CITY	STATE	ZIP CODE

BILLING METHOD

☐ PAYMENT ENCLOSED **$** _____

☐ PAYROLL DEDUCTION **$** _____ **(Employee's signature is required to authorize payroll deduction)**

	ENTER AGENCY NAME	ENTER AGENCY CODE
☐ DEPARTMENTAL BILLING **$** _____		

AUTHORIZING SIGNATURE *(Employee **OR** Department)*

PRINTED NAME

SIGNATURE	DATE SIGNED